Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965368	A. BUILDING: _____ B. WING _____	R 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AT OCOEE	80 NORTH CLARK RD OCOEE, FL 34761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit to Complaints #2023001985, #2023004936 and #2023008244 was conducted at Madison at Ocoee on . The facility had deficiencies at the time of the visit.	{A 000}		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician	A 010		

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A 010	Continued From page 1 who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

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A 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a [illegible]-to-[illegible] medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a [illegible], [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within	A 010		

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A 010	Continued From page 3 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.	A 010		

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A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on resident record review, observation, and interview, the facility failed to obtain a dated AHCA Form, 1823 Health Assessment completed by the healthcare provider for continued residency after a significant change for 1 of 4 sampled residents (#6) as required in an assisted living facility (ALF). Findings: A record review revealed a facility's admission date on . An undated Health Assessment Form (1823) indicates the diagnoses of , stable uses a walker and needs assistance with self-administration. On at 2:06pm The Wellness Director stated 1823 is probably from the Rehab. The nurses usually check the forms when the resident comes in. On at 3:00pm The Wellness Director confirmed the findings. Class III	A 010		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is	A 052		

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A 052	Continued From page 5	A 052		

prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers.
(b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change.
(c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her .
(d) Applying , medications.
(e) Returning the medication container to proper storage.
(f) Keeping a record of when a resident receives assistance with self-administration under this section.
(g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the .
(4) Assistance with self-administration of medication does not include:
(a) Mixing, , , converting, or , medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.
(b) The preparation of syringes for injection or the

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A 052	Continued From page 6 administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S.	A 052		

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A 052	Continued From page 7 and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and	A 052		

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A 052	Continued From page 8 dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's . . . . control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record review the facility failed to ensure the unlicensed staff, who assisted 2 of 2 sampled residents with medication followed the correct procedures (#13 & #14). Findings: 1. Observations made on . . . . . at 3:17pm revealed that Med Tech G did not keep the keys to Med Cart 1 on his person. Med Tech G arrived at the cart and removed the keys from a binder that is left on the cart during the day. The Med Tech, after removing the keys unlocked the cart and opened several drawers to search for the , ox which was required for his med passes. Discovering the , . . . ox was not present on the cart. The Med Tech left several drawers open and entered the nursing station. After locating the , ox, Med Tech G proceeded to begin his med pass. On at 3:22pm resident #13's med pass revealed that Med Tech G arrived at	A 052		

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A 052	Continued From page 9 resident #13's room and after knocking, acknowledged resident by name, and stated I have your medication. The Med Tech returned to the unlocked cart to review resident #13 Medication Administration Record (MAR). The Med Tech then retrieved the medication package from the cart, removed the tube from the box, and failed to lock the med cart before entering the resident's room. After entering resident #13's room, the med tech opened the tube, poured the medication into the . . . . . , and handed it to the resident. The Med Tech started the machine and informed resident #13 he would return in . . . minutes to check on her. Med Tech G returned to the unlocked cart to update the MAR but wasn't updated. The Med Tech did not sanitize his before or after the med pass, take the med pack from the cart to the resident, he did not state the name or dose of the medication, he exited the room after starting the , and he administered the wrong medication. On . . . . . at 3:28pm the Wellness Director was immediately notified of the improper med pass conducted by med tech G. The Wellness Director stated this is PRN and stated to Med Tech G you know you don't administer PRN unless the resident asks for it. The Wellness Director stated you need to inform the resident you gave her the wrong meds, stop the , and give her the correct medication. On . . . . . at 3:50pm Med Tech G stated, my bad, I didn't check the meds to the MARs before administering the medication to resident #13. I usually check, guess I'm just nervous. I've never had to pass meds with the state.	A 052		

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A 052	Continued From page 10 On . . . . . at 3:50pm Med Tech G stated that's what I usually do, leave the keys on the cart in the book. No one ever told me that I couldn't leave them. I think the other med tech knows, Caregiver I. Med Tech G stated, no, the wellness director does not know that's what I do. On at 10:33am Resident #13 stated she was unaware that Med Tech G had administered the wrong medication. Resident stated she is unaware if this has ever happened before. The resident stated the staff does not state the name or dose of the medication they just bring them to me. 2. Observations made on at 3:45pm Med Tech G arrived at resident #14's room and after knocking to ensure resident #14 was present, He acknowledged resident by name and stated I have your medication. The Med Tech unlocked the cart to retrieve the medication which was a . . . . . The Med Tech updated the book and then proceeded to pre-pop the medication into a cup in the hallway. The Med Tech then asked if he could leave the medication card with me while he goes into the room. The med tech returned the medication card to the cart leaving unlocked before entering the resident's room to administer the medication. The med tech handed resident #14 the cup and did not state the name or dose. The resident took the pill without help. The Med Tech returned to the cart and updated the MARs. The Med Tech did not sanitize his before or after the med pass, take the med pack from the cart to the resident and prepare it in the resident's presence, and he did not state the name or dose of the medication.	A 052		

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A 052	Continued From page 11 On at 3:50pm Med Tech G stated, I don't remember what I learned in training; it was an online course about a year ago. Med Tech G stated, I recently took a refresher course a couple of months ago held at the facility. Med Tech G stated, I didn't know I needed to pop the meds in the presence of the resident. That probably just slipped my mind. Oh, I forgot to sanitize my in between residents. On at 10:28am Resident #14 stated he has no issues with his medications. Resident stated the staff does not state the name or dose. They just bring it and tell me to take it. On at 3:50pm Med Tech G stated that's what I usually do, leave the keys on the cart in the book. No one ever told me that I couldn't leave them. I think the other med tech knows, Caregiver I. Med Tech G stated, no, the wellness director does not know that's what I do. On at 4:26pm The Wellness Director stated yes, Med Tech G had recently completed the refresher course held at the facility by the pharmacy for about two months. I can't believe he made those errors. The Wellness Director stated Med Tech G has been taken off the med cart. Class III .	A 052		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer	A 054		

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A 054	Continued From page 12 managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure medication for 3 of 4 residents was properly charted (#3, #6, #13). Findings: 1. Review of Resident #3 medication	A 054		

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A 054	Continued From page 13 administration record (MARs) code 11= meds not available, 9=other/see progress notes, and progress notes indicated the resident did not receive medication on , , , , , , , , and for , , , , and , , . On at 2:10pm The Wellness Director stated it's hard to give to her at night because she's sleeping, or she refuses. The staff is putting the wrong code because the medications are available and are on the cart. The Wellness Director confirmed the staff updated the MARs incorrectly. 2. Review of Resident #6 medication administration record (MARs) code 11= meds not available, 9=other/see progress notes, and progress notes indicated the resident did not receive medication on , , , , , , , , and for , . On at 10:22am Resident #6 stated she no longer needs the medication for , stones. The resident stated she had passed them. Resident #6 stated she has not run out of her medication, missed any doses, or had to wait for refills. On at 11:55am Caregiver I stated the medication was not available for resident #6 and checked the cart to confirm that it had not come in. Caregiver I stated she did not see a reorder on file. On at 12:04pm Caregiver I stated she verified with the nurse and the medication was ordered on the 16th of and it has not come in yet.	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965368	A. BUILDING: ______ B. WING ______	R 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AT OCOEE	**80 NORTH CLARK RD OCOEE, FL 34761**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 054	Continued From page 14	A 054		

On at 2:06pm The Wellness Director stated the medication is for resident #6 stones. The Wellness Director stated the resident probably passed the and the nurse didn't take it off.

On at 3:00pm The Wellness Director stated she confirmed that the nurse received a verbal order from the doctor to discontinue the medication and no refill was needed. The Wellness Director confirmed the MARs were not updated.

3. Review of Resident #13 medication administration record (MARs) code 11= meds not available, 9=other/see progress notes, and progress notes indicated the resident did not received medication on , , , , , , , , , , , , and .

On at 10:33am Resident #13 stated she has not run out of her medications and does not recall missing any doses.

On at 1:35pm The Wellness Director stated after reviewing resident #13 MARs, it was initialed, so she got it.

On at 1:35pm After reviewing the code 11=med not available and 9=other/see progress notes to the legend, The Wellness Director stated, I don't think she ran out. I'm thinking it's the med tech when she works a double. She's not finding the medication on the cart and not even reporting it. I'm noticing it's a pattern with her. The medications I'm sure are here, the staff is just not giving and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965368	A. BUILDING: _____ B. WING _____	R 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON AT OCOEE	80 NORTH CLARK RD OCOEE, FL 34761

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A 054	Continued From page 15 communicating that. Not all the medications are pre popped and the other techs are not questioning if a medication is still on the card. The med techs not nurses. Review of Resident #13 MARs stated the resident was hospitalized [redacted] and [redacted]. On [redacted] the drug [redacted] was updated as administered at 2100. On [redacted] at 1:35pm The Wellness Director confirmed the [redacted], was not updated correctly and resident #13 did not receive as she was in the hospital [redacted]. Class III	A 054		